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Roe v. Wade 25 years later

THE NEW ABORTIONS

HOW TECHNOLOGY WILL—AND WON'T—CHANGE THE POLITICS OF CHOICE

BY MARK SCHOOFS

FORGET about surgery. Since medical science can tell if a woman is pregnant eight to 10 days after intercourse, when the "gestational sac" is smaller than a pea, an abortion can be induced with a hand-held syringe or by swallowing a pill. And for women who don't want to wait even that long, morning-after "emergency contraception" can prevent a pregnancy from taking hold.

"The religious right is terrified," says Ronald M. Green, a Dartmouth ethicist. "Once a woman does not have to visit a picketed abortion clinic but can terminate a pregnancy in the privacy of her own doctor's office, then the prolife community has lost." This belief is increasingly common—so much so that it might be lulling some supporters of choice into thinking that science and technology will, on their own, end the abortion struggle.

That won't happen. Medicine that induces abortion has been legally available for decades, yet it hasn't softened the battle. In fact, most women probably don't even know their options, partly because boycott threats have discouraged pharmaceutical companies from bringing existing products to market, and because right-wing lobbyists have obstructed government-funded research on potential abortifacients. Politics matters.

But even if abortion pills were widely available, surgical abortions would still be in demand. In France, where the abortion pill RU-486 has been available for years, 70 per cent of abortions are still surgical, not chemical.

That's partly because medical abortion—the term commonly used for abortion-by-pill—is not exactly like popping a couple of aspirin. Abortifacients can cause chills, nausea, diarrhea, and cramping, not to mention heavy bleeding. "It can be a 15-day traumatic experience," says Maria Lacarra, a nurse at USC School of Medicine who has walked many women through medical abortions. For some women, she says, such abortions can be "psychologically more stressful."

The right uses these facts. "Waiting to expel the fetus is a horror in itself," warns Helen Alvaré of the National Conference of Catholic Bishops, "and you might expel it in the shower or the car." And, she says, "Doctors who won't do abortions surgically won't do them chemically."

But, in fact, many will. According to Planned Parenthood's Alan Guttmacher Institute, about a third of OB-GYN doctors who don't currently perform surgical abortions would prescribe medication for chemical ones. While pills may not be painless, they could eventually allow women to have abortions at home, after getting a single prescription. Science won't end the abortion struggle, but it will tilt the field.

SO IF A WOMAN has unprotected sex and doesn't want a baby, what are her options? That depends on how fast she acts. The quicker the better, but she should always see a doctor. Attempting any of the following alternatives without professional help can be dangerous.

For 72 hours after unprotected intercourse, a woman can avoid abortion through "emergency contraception," a morning-after procedure that cuts the risk of pregnancy by 75 per cent or more. In the most common method, a woman takes high doses of certain birth-control pills that contain the hormones estrogen and progestin—two times, 12 hours apart. Unfortunately, this so-called "Yupze regimen" causes nausea in half the patients, and 20 to 25 per cent vomit. Taking progestin alone appears to be just as effective, and only about 5 per cent of women experience vomiting.

These methods apparently prevent or delay ovulation, but may also interfere with fertilization or inhibit an embryo from implanting in the uterus. Nevertheless, pharmaceutical companies fear their pills will be tarred as abortifacients, says Nancy Alexander, an emergency-contraception researcher with the National Institutes of Health. There are seven pills on the U.S. market that could be used for morning-after contraception, she notes, but "no company has come out with a packet you could keep in the medicine cabinet."

Another postcoital option is a copper-T IUD. Inserted within five days of unprotected sex, it reduces the chance of pregnancy by more than 95 per cent. But if a woman hasn't had children, an IUD can be difficult to insert, and it isn't cheap. None of the emergency contraception methods offer any protection against sexually transmitted diseases, such as HIV.

EIGHT DAYS AFTER intercourse, a supersensitive test can reveal whether a woman is pregnant. Using a small syringe, a doctor can then perform a safe, modern version of the old suction abortions. An ultrasound test can determine whether the tiny gestational sac has indeed been removed.

From this point through eight weeks, women can also have a chemical abortion. The most common method, used by about half a million women in Europe, involves RU-486. That drug blocks the hormone progesterone, which is necessary to sustain the early stages of pregnancy. Two days later, the woman takes a drug called misoprostol, which causes uterine contractions similar to a miscarriage. Another drug, methotrexate, can be used in place of RU-486. This cancer drug blocks cell division, and so stops the embryo from growing. As with RU-486, misoprostol is given five days later to expel the fetus.

Both these methods—and others, such as an experimental protocol using the breast cancer drug tamoxifen—require two different medications. But Lacarra and her colleague Daniel Mishell, among others, have been experimenting with misoprostol alone, administered with a saline solution. It appears to work more than 90 per cent of the time. And, says Mishell, "There's no reason women couldn't put the pills in their vagina themselves at home." Lacarra agrees—"as long as her doctor explains what to expect," so that the side effects and the bleeding, which can include large clots, do not make women panic.

SUCH MEDICAL METHODS—all legal, except for RU-486, which should be fully approved in two years—are shifting the politics of abortion right now. But as we march into a future of cloning and genetic engineering, science will change the abortion debate yet again.

Already, scientists can retrieve fetal blood cells from the mother's blood soon after conception—and those cells can be genetically tested. At the moment, such testing is limited to horrific and incurable diseases, such as Tay-Sachs and cystic fibrosis. But there's no scientific obstacle to screening for the already-discovered genes that lead to deafness and obesity. What about albinism? Height? Homosexuality? As genetic tests proliferate, eugenic abortions will almost certainly increase.

Still, many women wouldn't abort, except in cases of the most severe abnormalities. But what if women could act before they got pregnant? Because of a little-noticed scientific accomplishment last year—the successful freezing of human egg cells—a woman can freeze her eggs until she's ready to have children, fertilize them in test tubes, and select only the "best" embryos. In the future, "choice" will mean not only *whether* to bear a child, but also *what kind* of child to bring into the world. V

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